Please reply to: Licensure Unit
PO Box 94986, Lincoln, NE 68509-4986
Phone (402) 471-2118
FAX (402) 471-3577

DHHS
Nebraska Department of Health and Human Services
Division of Public Health

Dear Applicant:

Thank you for your interest in becoming licensed to practice medicine and surgery in the State of Nebraska. Prior to submitting your application for licensure, it is important that you be aware of certain aspects of the application process.

The application form includes a series of questions about an applicant's history regarding licensure, physical and mental health, criminal conduct, and malpractice. I encourage you to read these questions carefully. It is expected that applicants answer these questions completely and truthfully. If others are assisting you in the completion of your application, make sure to review the information completely before signing the application. An adverse event in your past is not an automatic disqualification from licensure. The Board will review all of the information surrounding the event in making a determination of your fitness to practice medicine and surgery.

It is important that you fully disclose all arrests, charges or convictions. A question on the application asks not only about charges or complaints filed against you by any licensing or disciplinary authority, but it also asks for charges or complaints filed against you by any criminal prosecution authority. Even if the charges were dropped, dismissed, pled down or settled through diversion or if the sentencing was deferred or the conviction was expunged, set aside or pardoned, you must provide this information on the application. Failure to fully disclose could be considered as misrepresentation on your application which is grounds to deny your application for licensure.

Applicants are asked whether you have ever been convicted of a misdemeanor or felony. Some offenses that most people would consider as minor violations are actually misdemeanors, so it is important that you thoroughly review your history in order to provide accurate information regarding convictions. You may want to contact the court or seek the advice of an attorney to determine whether an event in your past resulted in a misdemeanor or felony conviction.

Applicants are asked whether you have ever been notified of any malpractice claim against you. This request includes all claims ever filed against you regardless of when they occurred or whether they were paid, settled or dropped.

Applicants should also be aware that it is the policy of the Licensure Unit that applications may not be withdrawn to avoid or circumvent a denial decision or to circumvent public records and reporting requirements. Understand prior to submitting your application that you may not be allowed to withdraw. Applicants who do not meet the requirements for licensure will be denied.

Thank you for taking the time to read this letter. I hope my comments are helpful to you. If you have further questions regarding the application process, please contact me by e-mail at becky.wisell@dhhs.ne.gov or by telephone at 402/471-2118.

Sincerely,

Becky Wisell

Becky Wisell, Administrator
Medical and Specialized Health
Licensure Unit

GENERAL INSTRUCTIONS FOR LICENSURE IN MEDICINE AND SURGERY AND OSTEOPATHIC MEDICINE AND SURGERY

HOW TO APPLY FOR A LICENSE

Examination Applications can be based on: United States Medical Licensing Examination (USMLE), National Boards of Medical Examiners (NBME), National Boards of Osteopathic Medical Examiners (NBOME), Federation Licensing Examination (FLEX), Licentiate of the Medical Council of Canada (LMCC), or a State Board Examination.

All parts of the examination must be passed within ten years of passing the first examination.
An applicant who fails to pass any part of the examination within four attempts must have completed one additional year of postgraduate medical education at an accredited school of medicine.

You must request that official documentation of passing scores obtained on all parts of each national examination you took be sent directly from the official repository of scores to this office (See below):

USMLE and FLEX contact FSMB at (817) 868-4041 website at www.fsmb.org
NBME (215) 590-9592 website at www.nbme.org
NBOME (773) 714-0622 website at www.nbome.org
LMCC (613) 521-6012

If you took a **State Board Examination** the Board of Medicine and Surgery will review the requirements under which you were licensed in the other state for comparability with Nebraska requirements. Please have the state in which you took the Board examination forward your scores to this office.

EDUCATION

US and Canadian Graduates: A certified final transcript sent directly from the medical school is the only acceptable document to verify your completion of medical school. Substitutions, such as letters from the Registrar are NOT acceptable.

Foreign Medical School Graduates: Must use the enclosed Verification of Foreign Medical College form to verify your medical school. Please have your medical school complete the form and send it directly to this office.

POSTGRADUATE MEDICAL EDUCATION

US and Canadian Graduates: Must have completed one year of ACGME accredited postgraduate education, or postgraduate education as approved by the Nebraska Board. You must use the enclosed Certificate of Post-Graduate Medical Education Form.

Foreign Medical School Graduates: Must have completed three years of ACGME postgraduate education, or postgraduate education as approved by the Nebraska Board. You must use the enclosed Certificate of Post-Graduate Medical Education Form.

Educational Equivalency Foreign graduates must possess a permanent Educational Commission on Foreign Medical Graduates (ECFMG) Certificate that is Valid Indefinitely. You must request that an official ECFMG Certification Status Report be sent directly to this office from ECFMG (215) 386-5900 and the website is www.ECFMG.org.

Fifth Pathway is also accepted and will require appropriate documentation.

PROFESSIONAL ACTIVITIES These must be listed for the last ten years or since graduating from medical college if less than ten years ago. Also, please list all periods of non-professional activity. This information is to be completed on the application form. PLEASE DO NOT PROVIDE CURRICULUM VITAE.

Criminal Background Check A criminal background check is required for all applicants for an initial license in medicine and surgery or osteopathic medicine and surgery. Please carefully follow the enclosed instructions for this procedure.

CONVICTION & LICENSURE INFORMATION If you answer "Yes" to any question(s) on pages 4 and 5 of the application you will be required to provide additional information regarding the circumstances and outcomes. Please refer to pages 7 and 8 of the application for specific information regarding the documentation required. After your application has been received, the Department/Board may request additional information based on your answers.

LICENSURE IN OTHER STATES List **ALL** states where you have ever held an active or inactive medical license to include: locum tenens, temporary medical license, and/or permanent medical license. **You will need to have each state where you have ever held a license send a certification of licensure to this office.**

COMPETENCY Present proof that **(see application for required documentation)**, within the three years immediately preceding this application for license, you meet one of the following criteria:

a. Have been in the active practice of the profession of medicine and surgery in some other state, a territory, the District of Columbia, or Canada for a period of one year;
b. Have had at least one year of approved graduate medical education;
c. Have completed continuing education in medicine and surgery approved by the Board;
d. Have completed a refresher course in medicine and surgery approved by the Board;
e. Have completed a special purposes examination approved by the Board.

PHOTOCOPY OF AN ACTIVE FEDERAL DEA CERTIFICATE must be sent with the application if controlled substances will be prescribed, administered or dispensed by the licensee.

FEES The expiration date for **ALL** Physicians and Osteopathic Physicians is October 1st of each even – numbered year. Determine the month and year in which you are submitting your application. Pay the amount in the corresponding box.

YEAR	Jan	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec
Even	$300	$300	$300	$75	$75	$75	$75	$75	$75	$300	$300	$300
Odd	$300	$300	$300	$300	$300	$300	$300	$300	$300	$300	$300	$300

*When a license will expire within 180 days after its initial issuance date the initial licensure fee is ¼ of the full fee. The full renewal fee will be due by October 1. You may request that your license be issued after October 1 by contacting our office.

WITHDRAWAL/DENIAL OF APPLICATION Once an application has been completed with all the required documents submitted, the applicant will not be allowed to withdraw the application. If the applicant does not meet the requirements for licensure, a denial will be issued.

LICENSURE TIMELINE Only completed applications will be considered for licensure. Please refer to the "Deadlines For Receipt of Licensure Applications and Supporting Documents" in this application for more information. The Department has up to 150 days to act upon any completed application. We are unable to provide estimates of the time it takes to obtain a license, as each application timeline will be unique.

LICENSE RENEWAL The period for biennial renewal of medical licenses in the State of Nebraska is October 1st of even-numbered years. Renewal notices are mailed at least 30 days prior to the expiration date of your license. **It is your responsibility to keep this office advised of your current address so that correspondence will reach you.**

NOTICE: All applications received on or after December 1, 2008 will need to include a copy of the following:

1. Age: Evidence of at least 19 years of age (i.e.: driver's license, birth certificate, marriage license, school transcript, US State ID card, Military ID, or similar documentation. Documents listed below which include date of birth will also suffice);

2. Citizenship, lawful permanent residence, and/or immigration status Information: You must submit a **copy** of at least one of the following documents:
   (1) A U.S. Passport (unexpired or expired);
   (2) A birth certificate issued by a state, county, municipal authority or outlying possession of the United States bearing an official seal;
   (3) An American Indian Card (I-872);
   (4) A Certificate of Naturalization (N-550 or N-570);
   (5) A Certificate of Citizenship (N-560 or N-561);
   (6) Certification of Report of Birth (DS-1350);
   (7) A Consular Report of Birth Abroad of a Citizen of the United States of America (FS-240);
   (8) Certification of Birth Abroad (FS-545 or DS-1350);
   (9) A United States Citizen Identification Card (I-197 or I-179);
   (10) A Northern Mariana Card (I-873);
   (11) An Alien Registration Receipt Card (Form I-551, otherwise known as a "Green Card");
   (12) An unexpired foreign passport with an unexpired Temporary I-551 stamp bearing the same name as the passport;
   (13) A document showing an Alien Registration Number ("A#"); or
   (14) A Form I-94 (Arrival-Departure Record);

CRIMINAL BACKGROUND CHECKS
Instructions

LB 306 was passed by the 2005 Nebraska Legislature. This law goes into effect September 4, 2005, and will be codified as Neb. Rev. Stat. §71-104.01.

> An applicant for an initial license to practice a profession which is authorized to prescribe controlled substances as determined by the department shall be subject to a criminal background check. The applicant shall submit with the application a full set of fingerprints which shall be forwarded to the Nebraska State Patrol to be submitted to the Federal Bureau of Investigation for a national criminal history record information check. The applicant shall authorize release of the results of the national criminal history record information check to the department. The applicant shall pay the actual cost of the fingerprinting and criminal background check. This section shall not apply to dentists who are applicants for temporary practice rights (locum tenens) under subdivision (5) of section 71-183.01 or to physicians and surgeons who are applicants for temporary practice rights (locum tenens) under subdivision (17) of section 71-1,103.

To avoid delays in processing your application for licensure, fingerprints should be obtained and submitted to the Nebraska State Patrol at the same time as you submit your application for licensure to the Department.

Fingerprinting Procedure

1. **If you received a printed application from our office,** two fingerprint cards were enclosed. Take the fingerprint cards to any State Patrol office or law enforcement agency. Contact information for the Nebraska State Patrol offices is included with these instructions. No appointment is necessary for the Lincoln location. The Lincoln location is open Monday through Friday, 8 a.m. to 4 p.m. for fingerprinting. You must call ahead to schedule an appointment at the Nebraska State Patrol offices located outside of Lincoln to ensure that someone will be there to conduct the fingerprinting. These offices have limited hours when fingerprinting will be conducted.

2. The Nebraska State Patrol does not charge for the service of taking your fingerprints. However, other law enforcement agencies in Nebraska or other states may charge a fee.

3. **If you obtained your application online,** fingerprint cards can be obtained by contacting our office or from any State Patrol office or law enforcement agency.

4. **DO NOT FOLD THE FINGERPRINT CARDS.**

5. You must take one form of photo ID with you when obtaining your fingerprints. Acceptable forms of ID include a driver's license, visa or passport. If you are from a foreign country and do not have one of these forms of photo identification, provide any documentation issued by your country, legal sovereign or consulate.

6. You may print your name, address, Social Security Number, date and place of birth, and physical identifiers on the fingerprint cards. **DO NOT sign the fingerprint cards** until the law enforcement officer has verified your signature with the form of identification that you provide. **DO NOT write in the field labeled ORI.** In the space on the fingerprint cards marked "Reason Fingerprinted", you should print the following: "**R & L Health Credentialing**".

7. After the fingerprinting procedure is completed, the cards will be given to you. **DO NOT FOLD THE FINGERPRINT CARDS.** Place the cards in the envelope provided (if you obtained the cards from us), along with a personal check, money order or cashier's check for the appropriate fee listed below, payable to the Nebraska State Patrol, and drop it in the mail. If you obtained the cards from a State Patrol office or other law enforcement agency, you will need to place the cards and the payment in an envelope addressed to:

Nebraska State Patrol
ATTN: CID
233 South 10th St, Suite 101
Lincoln, NE 68508

Fees

Fingerprints submitted on or after June 1, 2006, must include payment of $38.00.

8. It may take several weeks for your criminal background check to be received by the Department. No licensing decision will be made until all information is received.

Offices of the Nebraska State Patrol	Days/Hours that Fingerprinting is Conducted
Troop A 4411 S. 108th St. Omaha, NE 68137 Phone: 402/331-3333	**Beginning January 2, 2007** Monday through Friday 8:00 a.m. to 4:30 p.m. (no appointment necessary)
Troop B 1401 Eisenhower Ave. Norfolk, NE 68701 Phone: 402/370-3456	Usually on Tuesdays (appointment required)
Troop C 3431 Potash Grand Island, NE 68802 Phone: 308/385-6000	Mondays from 10:00 a.m. to noon and from 1:00 p.m. to 2:45 p.m. (appointment required)
Troop D 300 West South River Road North Platte, NE 69101 Phone: 308/535-8265 ext. 219	Monday, Tuesday, Thursday, Friday from 8:30 a.m. to 5:00 p.m. Wednesday from 8:30 a.m. to 2:30 p.m. (appointment required)
Troop E 4500 Avenue I Scottsbluff, NE 69361 Phone: 308/632-1211	Wednesdays after 1:00 p.m. (appointment required)
Criminal Identification Division (CID) 233 S. 10th St. Lincoln, NE 68508	Monday through Friday 8:00 a.m. to 4:00 p.m. (no appointment necessary)

Deadlines For Receipt of
Licensure Applications and Supporting Documents

For applications for a license to practice medicine & surgery, osteopathic medicine & surgery and temporary educational permits.

Following are the deadlines for receipt of licensure applications and supporting documents for applications required to be reviewed by the Board of Medicine and Surgery. Some applications will require review by the Board of Medicine and Surgery at their regular meeting. These deadlines will apply if the Department determines that your application will need Board review. Please submit your application according to this schedule, assuming that your application will be reviewed by the Board. If your application does not need Board review, you will receive a license document in the mail.

1) APPLICATION DEADLINE DATE	2) DOCUMENTS DEADLINE DATE	3) MEETING DATE
November 24, 2008	January 2, 2009	January 23, 2009
January 16, 2009	February 27, 2009	March 20, 2009
March 6, 2009	April 17, 2009	May 8, 2009
April 17, 2009	May 29, 2009	June 19, 2009
June 5, 2009	July 17, 2009	August 7, 2009
July 31, 2009	September 11, 2009	October 2, 2009
September 18, 2009	October 30, 2009	November 20, 2009
November 18, 2009	December 31, 2009	January 22, 2010

1) **Application deadline:** The completed application form and check/money order must be received in our office by this date. Late applications WILL BE referred to the next application deadline.

2) **Documents deadline:** All supporting documents and additional information that our office requests must be received in our office by this date. Late submissions will cause your application to be reviewed at the next meeting date.

3) **Dates of the regular meetings of the Nebraska Board of Medicine & Surgery.**

This form may be completed online and mailed to the address listed below.

Lic#_____

Date:_____

DHHS
NEBRASKA
Department of Health and Human Services
Division of Public Health - Licensure Unit
P.O. Box 94986 - Lincoln, Nebraska 68509-4986
Telephone #: 402-471-2118

APPLICATION FOR A LICENSE TO PRACTICE:

☐ **Medicine and Surgery** ☐ **Osteopathic Medicine and Surgery**

(Please print or type application)

Fee: $300

SECTION A - LICENSE APPLICATION CATEGORY and FEES (All applicants must complete this section) **Check the category which applies**

☐ Licensure by Examination(National Examination) ☐ Licensure Based on License in Another State (State Examination)

SECTION B– PERSONAL INFORMATION (All applicants must complete this section) **Items 1 and 2 are public information and will be displayed on the INTERNET http://www.nebraska.gov/LISSearch/search.cgi**

NOTE: All mailings will be sent to the address you indicate below– if you change your address, you must advise this office.

1	Legal Name	First:	Middle/MI:	Last:	
	Maiden Name	Name:	Other Names you are known as (AKA):		
2	Mailing Address	Street/PO/Route:			
		City:	State or Country:	Zip:	
3	Date of Birth:	Month/Day/Year:	Place of Birth:	City/State or Country:	
4	Check the Appropriate Box(s):	Social Security Number (SSN); Alien Registration Number ("A#"); or Form I-94 (Arrival-Departure Record) number	SSN#		
			A#		
			I-94 #		
	If you have both a SSN and an A# or I-94 number, you must report both. Social Security Numbers obtained are not public information but may be shared by the Department for administrative purposes if necessary and only under appropriate circumstances to ensure against any unauthorized access to this information.				
5	Check the Appropriate Box:	I am a citizen of the United States I am an alien lawfully admitted into the United States for permanent residence under the Immigration and Naturalization Act (INA and who is eligible for a credential under the Uniform Credentialing Act) I am a non immigrant whose visa for entry, or application for visa for entry, is related to such employment in the United States			
6	Phone #: (optional)		Fax #: (optional)		*Licensee* E-Mail Address: (optional)
					Credentialing contact Email address (optional):

SECTION C - EXAMINATION (All applicants must complete this section)

☐ I have requested that an official copy of my score reports for any and all of the following examinations that I have taken (check ALL that apply) be sent to your office:

Application by Examination:

☐ USMLE ☐ NBME ☐ FLEX ☐ NBOME ☐ LMCC

☐ Combination of USMLE/FLEX ☐ Combination of USMLE/NBME

Application Based on License in Another State or Territory of the United States:

☐ State Exam (list state) _____

SECTION D - EDUCATION (All applicants must complete this section) List in chronological order, beginning with medical school and ending with high school, the name and location of all institutions attended. Include the diplomas or certificates earned and dates received for all preliminary (high school), pre-medical education and medical education. (Attach additional pages if necessary).

Name of Institution **MEDICAL EDUCATION**			
City/State/Country			
Attended From	(M/D/Y)	Attended From	(M/D/Y)
Degree Conferred (MD, DO, MBBS, etc)		Degree Conferred (MD, DO, MBBS, etc)	

PRELIMINARY AND PRE-MEDICAL EDUCATION	
Institution	
City/State/Country	
Diploma/Certificate	
Date: (MO/YR)	
Institution	
City/State/Country	
Diploma/Certificate	
Date: (MO/YR)	

Foreign medical graduates must indicate their ECFMG number here: _____

SECTION E – POST-GRADUATE MEDICAL EDUCATION- Indicate whether service was Internship, Residency or Fellowship.

Name of Institution	
Name of Specialty	☐ Internship ☐ Residency ☐ Fellowship
City/State/Country	
Attended From:	(M/D/Y)
Attended To:	(M/D/Y)
Name of Institution	
Name of Specialty	☐ Internship ☐ Residency ☐ Fellowship
City/State/Country	
Attended From:	(M/D/Y)
Attended To:	(M/D/Y)
Name of Institution	
Name of Specialty	☐ Internship ☐ Residency ☐ Fellowship
City/State/Country	
Attended From:	(M/D/Y)
Attended To:	(M/D/Y)

SECTION F– MAINTENANCE OF COMPETENCY- Indicate that, within the three years immediately preceding the application for licensure, you meet one of the following criteria:

☐	**I have been in the active practice of the profession of medicine and surgery in some other state, a territory, the District of Columbia, or Canada for a period of one year.**
☐	**I have had at least one year of approved graduate medical education.**
☐	**I have completed continuing medical education.** Submit proof of attendance at continuing education, as well as information about the content for Board approval.
☐	**I have completed a refresher course in medicine and surgery.** Submit proof of attendance at a refresher course, as well as information about the content for Board approval.
☐	**I have completed a special purposes examination.** Have your score sent directly to this office for Board approval.

SECTION G - PROFESSIONAL ACTIVITIES – List in chronological order all of your medical activities for the last ten years, or since graduation from medical college if less than ten years ago. Also list all periods of non-professional activity or employment for periods of non-medical activity of more than three months. Please account for all time and explain all gaps of more than three months. (Attach additional pages if necessary).

From: Month/Year		To: Month/Year	
Name of Facility			
City/State/Country			
Activity			
From: Month/Year		To: Month/Year	
Name of Facility			
City/State/Country			
Activity			
From: Month/Year		To: Month/Year	
Name of Facility			
City/State/Country			
Activity			
From: Month/Year		To: Month/Year	
Name of Facility			
City/State/Country			
Activity			
From: Month/Year		To: Month/Year	
Name of Facility			
City/State/Country			
Activity			

SECTION H – CONTROLLED SUBSTANCES REGISTRATION: (check one of the following)

1		I have enclosed a photocopy of my current Federal Controlled Substances Registration.	
		Federal Controlled Substances Registration #:	Expiration Date:
2		I am currently applying for a Federal Controlled Substances Registration, and will send a photocopy of such when I receive the registration.	
3		I do not have nor am I applying for a Federal Controlled Substances Registration and I will not be prescribing, administering or dispensing controlled substances in Nebraska. I understand that at such time that I do intend to prescribe, administer or dispense controlled substances in Nebraska, I will first need to have a Federal Controlled Substances Registration issued to me. At that time, I am to supply a photocopy of the registration to the State of Nebraska.	

SECTION I –LICENSURE IN OTHER STATES (All applicants must complete this section)

Have you ever been licensed as a physician in another state or jurisdiction?	☐ YES	☐ NO

List all other states, jurisdictions, or territories of the U.S. where you have been or are currently licensed, including license number, issue date, and expiration date. (Attach additional pages if necessary).

State	License #	Issue Date	Expiration Date

SECTION J – CONVICTION AND LICENSURE INFORMATION (All applicants must complete this section)
Failure to disclose any such conviction or disciplinary action, regardless of when the action occurred, could result in disciplinary action, including, but not limited to, payment of a civil penalty.

Note: If you have any criminal charges or license disciplinary actions pending that result in conviction or license discipline, you are required to report such actions to the Investigative Unit within 30 days http://www.dhhs.ne.gov/reg/investi.htm or by telephone at 402-471-0175.

Answer the following questions either yes or no by placing a (✓) in the appropriate box. All 'yes' responses MUST be explained in detail and you must submit the requested documentation (see page6 of application). Additional documentation may be requested by the Board/Department after submission of initial information.

Section I			
1	Have you ever had any disciplinary or adverse action imposed against a professional license or permit in any state or jurisdiction?	YES	NO
2	Have you ever voluntarily surrendered or voluntarily limited in any way a license or permit issued to you by a licensing or disciplinary authority?	YES	NO
3	Have you ever been requested to appear before any licensing agency?	YES	NO
4	Have you ever been notified of any charges, complaints or other actions filed against you by any licensing or disciplinary authority?	YES	NO
5	Are you aware of any pending disciplinary actions or of any on-going investigations of a complaint against your license or permit in any jurisdiction?	YES	NO
6	Have you ever been asked to and/or permitted to withdraw an application for licensure or permit with any Board or jurisdiction?	YES	NO
7	Has any state or jurisdiction refused to issue, refused to renew or denied you a license or permit to practice?	YES	NO

Section II			
1	Are you currently, or have you ever been, addicted to, dependent upon or chronically impaired by alcohol, narcotics, barbiturates, or other drugs which may cause physical and/or psychological dependence?	YES	NO
2	Within the past 5 years, have you received any therapy/treatment or been admitted to any hospital or other in-patient care facility for reasons relating to your use/abuse of alcohol, narcotics, barbiturates, or other drugs?	YES	NO
3	Do you currently, or have you ever had, any physical, mental, or emotional condition which impaired, or does impair your ability to practice your health care profession safely and competently?	YES	NO
4	Within the past 5 years, has any licensing agency or credentialing organization initiated any inquiry into your physical, mental or emotional health?	YES	NO
Section III			
1	Have you ever been restricted, suspended, terminated, requested to voluntarily resign, placed on probation, counseled, received a warning or been subject to any remedial or disciplinary action during medical school or postgraduate training?	YES	NO
2	Have you ever had hospital or institutional privileges denied, reduced, restricted, suspended, revoked, terminated or placed on probation?	YES	NO
3	Have you ever been requested to voluntarily resign or suspend hospital or institutional privileges while under investigation from a hospital, clinic, institution, or other medically related employment?	YES	NO
4	Have you ever been notified that any action against your hospital or institutional privileges is pending or proposed?	YES	NO
5	Have you ever been allowed to withdraw your staff privileges from a hospital or institution?	YES	NO
6	Have you ever been subject to staff disciplinary action or non-renewal of an employment contract?	YES	NO
Section IV			
1	Have you ever been convicted of a felony? **Failure to disclose any such convictions regardless of when the conviction occurred could result in disciplinary action, including but not limited to a minimum of $500 civil fine.**	YES	NO
2	Have you ever been convicted of a misdemeanor? **Failure to disclose any such convictions regardless of when the conviction occurred could result in disciplinary action, including but not limited to a minimum of $500 civil fine.**	YES	NO
3	Have you ever been notified of any charges, complaints or other actions filed against you by any criminal prosecution authority?	YES	NO
Section V			
1	Have you ever been denied a Federal Drug Enforcement Administration (DEA) Registration or state controlled substances registration?	YES	NO
2	Have you ever been called before any licensing agency or lawful authority concerned with DEA controlled substances?	YES	NO
3	Have you ever surrendered your state or federal controlled substances registration?	YES	NO
4	Have you ever had your state or federal controlled substances registration restricted or disciplined in any way?	YES	NO
Section VI			
1	Have you ever been notified of any professional liability claim that resulted in an adverse judgment, settlement, or award, including settlements made prior to suit in which the patient releases any professional liability claim against the applicant?	YES	NO
2	Are you aware of any professional liability claims currently pending against you?	YES	NO

SECTION K – PRACTICE PRIOR TO CREDENTIAL

An individual who practices prior to issuance of a credential is subject to assessment of an Administrative Penalty of $10 per day up to $1,000, or such other action as provided in the statutes and regulations governing the credential.

1	I have practiced as a physician/osteopathic physician & surgeon in Nebraska before submitting the application.	YES	NO
2	If yes, what are the actual number of days you practiced in Nebraska and what is the business name, location and telephone number of the practice: ***Students of medicine and surgery enrolled in an accredited college of medicine who gratuitously practice medicine and surgery under the supervision of a licensed physician are exempt from needing a Permit or License in the State of Nebraska, pursuant to Neb. Rev. Stat. 38-2025(4)). Once an individual has graduated from medical school, however, a Permit or License is required in the State of Nebraska in order to practice medicine and surgery. The question above, therefore, refers to the time since you have graduated from medical school until such time as you have received a Permit or License to practice medicine and surgery in the State of Nebraska.***	# of days: _____ Name of Business: City: Telephone #:	

SECTION L - ATTESTATION

I attest that:
1. I have read the application or have had the application read to me;
2. All statements on the application are true and complete; and
3. I am of good character.

_____ _____

(Signature of Applicant) (Date)

NOTE: In order for your application to be considered complete, all applicants MUST also submit a copy of the following documents:

1. Age: Evidence of at least 19 years of age (i.e.: driver's license, birth certificate, marriage license, school transcript, US State ID card, Military ID, or similar documentation);

2. Citizenship, lawful permanent residence, and/or immigration status Information: You must submit a **copy** of at least one of the following documents:

   (1) A U.S. Passport (unexpired or expired);
   (2) A birth certificate issued by a state, county, municipal authority or outlying possession of the United States bearing an official seal;
   (3) An American Indian Card (I-872);
   (4) A Certificate of Naturalization (N-550 or N-570);
   (5) A Certificate of Citizenship (N-560 or N-561);
   (6) Certification of Report of Birth (DS-1350);
   (7) A Consular Report of Birth Abroad of a Citizen of the United States of America (FS-240);
   (8) Certification of Birth Abroad (FS-545 or DS-1350);
   (9) A United States Citizen Identification Card (I-197 or I-179);
   (10) A Northern Mariana Card (I-873);
   (11) An Alien Registration Receipt Card (Form I-551, otherwise known as a "Green Card");
   (12) An unexpired foreign passport with an unexpired Temporary I-551 stamp bearing the same name as the passport;
   (13) A document showing an Alien Registration Number ("A#"); or
   (14) A Form I-94 (Arrival-Departure Record);

3. Education: Your medical school (U.S. or Canadian) must submit an official school transcript. Foreign medical graduates must have your school fill out the Foreign Medical College Form attached to this application (documents not written in English must be accompanied by an official English translation);

4. Examination: Official Score Reports sent directly to our office from the entity indicated:

   USMLE and FLEX contact FSMB at (817) 868-4041 website at www.fsmb.org
   NBME (215) 590-9700 website at http://www.nbme.org
   NBOME (773) 714-0622 website at www.nbome.org
   LMCC (613) 521-6012
   State Board Examination: Contact appropriate State Board

5. Foreign medical graduates: MUST have ECFMG send an official verification of their **permanent ECFMG Certificate that is valid indefinitely** directly to our office (the ECFMG phone number is 215-386-5900 and the website is www.ECFMG.org)

6. Post-graduate medical education: A Certificate of Post-Graduate Medical Education form (attached) must be completed by the Program Director. U.S. or Canadian graduates must show successful completion of at least one year of postgraduate medical education in the U.S. or Canada. Foreign graduates must show at least three years of postgraduate medical education in the U.S. or Canada or approved graduate medical education. Documents not written in English must be accompanied by an official English translation.

7. Licensure in other States: Direct source verification/certification of any physician license that you hold or have held is required. You will need to request that each state or jurisdiction send a verification/certification of your license directly to our office.

8. Conviction Information: If you have been convicted of a felony or misdemeanor, you must submit:

   a. A copy of the court record, which includes charges and disposition;
   b. Explanation from the applicant of the events leading to the conviction (what, when, where, why) and a summary of actions you have taken to address the behaviors/actions related to the convictions;
   c. All addiction/mental health evaluations and proof of treatment, if the conviction involved a drug and/or alcohol related offense and if treatment was obtained and/or required; and
   d. A letter from the probation officer addressing probationary conditions and current status, if you are currently on probation;

9. Malpractice Information: Please include the following information. Sign and date your explanation.

   a. State the **total number of claims ever filed against you;** and
   b. Submit a **detailed explanation** (see below) of each claim ever filed against you. Do not send copies of forms completed for insurance companies or other entities.
   c. For any malpractice claims that are **currently pending**, submit copies of the court documents that outline the statement of charges (often called the "Complaint") and a letter from the attorney stating the current status of the claim.

   Include the following information regarding each claim:
   1. Name, sex and age of patient
   2. Date of occurrence
   3. Initial event (procedure/diagnosis)
   4. Subsequent event that precipitated the claim – include the time sequence in relation to the initial event
   5. Damages – a description of damages or alleged damages resulting from the initial and subsequent events
   6. Date of filing of malpractice claim in court (if applicable)
   7. Outcome of claim – include the court disposition, whether or not the case was settled, and the amount of any monetary settlement or judgment made on your behalf. If no money was paid on your behalf, you must indicate this
   8. Date of final outcome of claim.

10. Disciplinary Action: If you have had any disciplinary actions taken against your credential, you must submit a copy of the disciplinary action(s), including charges and disposition.

11. Fee: The required fee (see chart below).

YEAR	Jan	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec
Even	$300	$300	$300	$75	$75	$75	$75	$75	$75	$300	$300	$300
Odd	$300	$300	$300	$300	$300	$300	$300	$300	$300	$300	$300	$300

Any documents written in a language other than English must be accompanied by a complete translation into the English language. The translation must be an original document and contain the notarized signature of the translator. An individual may not translate his/her own documents.

State of Nebraska
Department of Health and Human Services
Licensure Unit
P O Box 94986
301 Centennial Mall South
Lincoln, NE 68509-4986
(402) 471-2118

CERTIFICATE OF POST-GRADUATE MEDICAL EDUCATION

Applicants must have the **current Program Director** of the institution where they completed their post-graduate medical education complete the following form and **affix the Official School Seal**. An **original** signature from the Program Director is required. Please mail the form directly to the address printed above.

Print Name _____ **SS#** _____

NOTE: The information below must be completed ONLY by an official of the program/facility.
NOT TO BE COMPLETED BY APPLICANT

It is hereby certified that: _____
(Name of Applicant)

Has successfully completed _____
(Name of Residency/Internship/Fellowship)

located at : _____ **in** _____
(Name of Hospital/Teaching Institution) (City, State, Country)

From _____ **To** _____
(Month/Day/Year) (Month/Day/Year)

At the time this applicant was enrolled in this Program, this Program was:

_____ **ACGME* or AOA* accredited**
*ACGME - Accreditation Council for Graduate Medical Education
*AOA – American Osteopathic Association

_____ **RCPSC* or CFPC* accredited**
*RCPSC – Royal College of Physicians and Surgeons of Canada
*CFPC – College of Family Physicians of Canada

_____ **was not accredited by any of the above listed entities**

Any Disciplinary Action? Yes _____ No _____ If yes, provide details of the disciplinary action.

Any Derogatory Information on File? Yes _____ No_____ If yes, provide details of the derogatory information.

Signature _____
Signature of CURRENT PROGRAM DIRECTOR
(Signature stamp **NOT** acceptable)

Print Name_____

Title _____

Date (month/day/year) _____

Phone # _____

Fax # _____

E-mail _____

INSTITUTIONAL SEAL

(If your institution does not have an official seal, this form must be notarized)

FOREIGN MEDICAL GRADUATES:

IN ORDER TO EXPEDITE THE DIRECT SOURCE VERIFICATION OF YOUR MEDICAL SCHOOL DEGREE, YOU NEED TO COMPLETE THE TOP PORTION OF THE ATTACHED FORM, ATTACH A PASSPORT SIZE PHOTOGRAPH OF YOURSELF IN THE BOTTOM PORTION OF THE FORM AND SEND THE FORM TO YOUR MEDICAL SCHOOL. THE MEDICAL SCHOOL WILL NEED TO COMPLETE THE LOWER PORTION OF THE FORM AND SEND THE FORM DIRECTLY TO OUR OFFICE.

SUBSTITUTIONS FOR THIS FORM WILL NOT BE ACCEPTED. PHOTOGRAPH MUST BE INCLUDED AND VERIFIED BY SCHOOL.

THIS FORM IS FOR FOREIGN MEDICAL GRADUATES ONLY.

Graduates of US or Canadian schools, please have your school send a certified final transcript or letter indicating date graduated and degree received.

State of Nebraska Department of Health and Human Services
Regulation and Licensure Credentialing Division
PO Box 94986, Lincoln NE 68509-4986 (402) 471-2118

VERIFICATION OF FOREIGN MEDICAL COLLEGE

_____
Name of University

_____
Street

_____
City State Zip

I, _____, MD/DO have applied for a license to practice in the State of
(Print full name)
Nebraska. As part of the application process, the State of Nebraska requires a verification of my Foreign Medical College.

I hereby authorize _____, its staff or representative to provide the State of
(Name of College)
Nebraska any and all information requested below, whether such information is favorable or unfavorable, and I hereby release from any and all liability the above named society and/or person for any and all acts performed in fulfilling this request, provided that such acts are performed in good faith and without malice. Further, I request that this completed form be sent directly to the State of Nebraska. I understand that completed forms returned to me will not be accepted for verification purposes.

Sincerely, _____ Date of Birth _____/_____/_____
(Signature of Applicant) MO DAY YEAR

Social Security Number _____ Date of Graduation _____/_____/_____
MO DAY YEAR

For verification of FOREIGN MEDICAL COLLEGE ONLY. Please provide exact dates. The following section must be completed by the dean or registrar of the foreign medical school and returned directly to the State of Nebraska. Verifications returned directly to the applicant will not be accepted. Do not complete if photograph is not attached. Any substitutions must contain all required information or it will not be accepted for verification purposes.

This certifies that _____
(full name of applicant)

Enrolled in _____
(Name of Foreign Medical College)

on _____/_____/_____ graduated _____/_____/_____
MO DAY YEAR MO DAY YEAR

and received the **DEGREE** of _____

Any disciplinary action on file? Yes (please explain)_____ No _____

Further, the records of this institution indicate that the attached photograph
(check one) _____ Represents a true likeness of the above named applicant
_____Does not represent a true likeness of the above-named applicant.

By _____ SEAL Attach
Original Signature of the dean or registrar Passport size
(stamped or electronic signatures will NOT be accepted) Photograph Here

_____
Print or Type Official's Name and Title

_____
e-mail address if possible

Signed and the college Seal affixed on _____/_____/_____ Medical College seal MUST be imprinted partially on photograph
MO Day Year